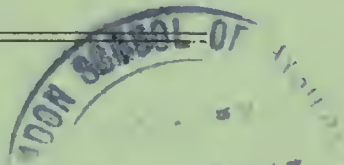


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RURAL DISTRICT OF DROXFORD

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ANNUAL REPORT

OF THE

MEDICAL OFFICER of HEALTH

AND

PUBLIC HEALTH INSPECTOR

for the year

1958



PETERSFIELD
THWAITES & WATTS, LAVANT STREET

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RURAL DISTRICT OF DROXFORD

ANNUAL REPORT
OF THE
Medical Officer of Health
AND
Public Health Inspector
FOR THE YEAR
1958

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DROXFORD RURAL DISTRICT COUNCIL

NORTHBROOK HOUSE,
BISHOP'S WALTHAM
SOUTHAMPTON
Tel. Bishop's Waltham 242

*To the Chairman and Members
of the Droxford Rural District Council*

I have the honour to present the Annual Report of the year 1958, on the health and sanitary circumstances of the Rural District of Droxford. It is drafted in accordance with the requirements of the Ministry of Health.

The estimated population showed an increase of 320.

Measles occurred in some of the villages which escaped the infection during the previous year and there was an outbreak of dysentery in Denmead.

At the end of October, a small outbreak of poliomyelitis commenced in Curdridge. Five cases occurred altogether affecting three pre-school children, one school child and one adult.

Vaccination against Poliomyelitis commenced on a large scale as the supplies of vaccine became available.

There has been no case of diphtheria in the district during the past six years ; but, in the country as a whole, for the first time in fourteen years, there has been a rise in the incidence of diphtheria.

Parents are again reminded that children should be immunised before their first birthday and should receive their first supplementary injection preferably just before school age.

I should like to thank you all for your help and encouragement and I am grateful to the Officers of other Departments for their willing help and assistance at all times.

I also wish to record my grateful thanks to Mr. Lindley, the Chief Public Health Inspector, and to Mr. Wenden and Mr. Knowlton for their valuable co-operation and assistance in compiling this report.

S. Chalmers Parry

Medical Officer of Health, Droxford Rural District Council.

LEGISLATION

The Clean Air Act, 1956 (Appointed Day) Order, 1958

This Order brought into operation, on the 1st June, the remaining provisions of the Act, including the prohibition of dark smoke from chimneys, measures for dealing with grit and dust from furnaces, and the abatement of smoke nuisances.

The Dark Smoke (Permitted Periods) Regulations, 1958

These regulations, which came into force on 1st June, specify the permitted periods for the emission of dark smoke.

Slaughterhouses Act, 1958

Came into force on 1st August, this Act deals with the licensing of private slaughterhouses, the safety, health and welfare of employees, and the methods of slaughter.

The Act also brings all slaughterhouses within the scope of the Factories Acts.

Slaughter of Animals Act, 1958

An Act to repeal and consolidate several previous Acts.

Slaughterhouses (Hygiene) Regulations, 1958

These regulations impose upon the occupiers of slaughterhouses requirements as to the construction, layout, drainage, equipment maintenance, cleanliness, ventilation, lighting, water supply, management of personnel hygiene. Certain of the Regulations, applying to the construction and lighting of existing slaughterhouses, will not come into operation until dates appointed by the Ministry.

Slaughter of Animals (Prevention of Cruelty) Regulations, 1958

Re-enacts several previous Regulations, the principal new provisions are, that stunning-pens are made compulsory for the slaughter of cattle on such dates to be appointed, certain provisions for the care of animals in lairages, and conditions for the licensing of slaughtermen.

STATISTICS OF THE AREA

Area	...	...	...	...	62,848 acres
" Home " Population (mid 1958)				...	21,290
Number of Hereditaments (31/3/59)				...	6,806
Rateable Value (31/12/58)		...	...	...	£228,960
Sum represented by a penny rate (31/3/58)					£910 7s. 3d.

NATURAL AND SOCIAL CONDITIONS OF THE AREA

The Rural District is situated in the south-east corner of Hampshire. The northern half lies on the chalk uplands and the remainder on the sands and clays of the Hampshire Basin. The principal watercourse is the Meon, a chalk stream and the only other rivers are the headwaters of two tertiary streams, the Hamble in the south-west and the Wallington in the south-east.

The differentiation in soils is reflected in land use ; on the chalk there is arable farming with units of comparatively large acreage, on the tertiary formation there are small dairy farms on the clay and extensive smallholdings with strawberry growing a speciality of the district, on the loams and sands.

The ancient Forest of Bere is being re-afforested by the Forestry Commission. These rural industries and related activities employ much of the population, though considerable numbers find employment in towns outside of the district.

VITAL STATISTICS

Births	1957			1958		
	M.	F.	Total	M.	F.	Total
Live Birth (Legitimate)	190	166	356	184	168	352
(Illegitimate)	6	5	11	7	5	12
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Total Live Births	...		367	...		364
			<hr/>			<hr/>

Live Birth Rate per 1,000 of the estimated population (mid-1958) was 17.1 compared with 16.4 for the whole of England and Wales. Illegitimate live births per cent of total live births was 3.3%.

	1957			1958		
	M.	F.	Total	M.	F.	Total
Still Births (Legitimate)	2	6	8	3	1	4
(Illegitimate)	—	—	—	—	—	—
Total Still Births	—	—	—	—	—	—
	...		8	...		4
			—			—

Still Birth Rate per 1,000 total (live and still) births was 10.8 compared with 21.6 for the whole of England and Wales.

Deaths

	1957			1958		
	M.	F.	Total	M.	F.	Total
From all causes	143	169	312	153	156	309

Death Rate per 1,000 estimated population was 14.5 compared with 11.7 for the whole of England and Wales.

Maternal Mortality

	1957	1958
Pregnancy, Childbirth, Abortion	...	1
		Nil

Maternal Mortality Rate per 1,000 total (live and still births), Nil

Infant Mortality (deaths under one year)

	1957			1958		
	M.	F.	Total	M.	F.	Total
Legitimate ...	1	2	3	3	4	7
Illegitimate ...	—	—	—	—	—	—
Total Infant Deaths	...		3	...		7
			—			—

Infant Mortality Rate per 1,000 live births was 19.2, compared with 22.5 for the whole of England and Wales.

This rate for each calendar year is not regarded as a reliable guide, for the number of births in the District is insufficient to be of significance statistically.

But, if this rate is taken over a period of five years, it may then be considered reasonably reliable and one of the best indices of the social circumstances of the district. High rates are commonly associated with overcrowding and defective sanitation.

It is therefore satisfactory to report that, during the past fifteen years, the quinquennial rates for this district have been consistently lower than the figures for the country as a whole.

The following table shows the rate for the district as compared with the rate for England and Wales, each over a five-year period.

INFANT MORTALITY RATE (per 1,000 live births)				
<i>Year</i>		<i>Droxford Rural District</i>		<i>England and Wales</i>
1942	...	47.1	...	52.0
1943	...	42.5	...	50.0
1944	...	33.2	...	46.6
1945	...	28.3	...	45.0
1946	...	28.5	...	42.0
1947	...	28.5	...	39.2
1948	...	26.3	...	35.9
1949	...	25.5	...	33.3
1950	...	23.7	...	30.6
1951	...	19.4	...	29.2
1952	...	15.0	...	27.8
1953	...	12.9	...	26.8
1954	...	12.1	...	25.76
1955	...	10.6	...	24.9
1956	...	12.28	...	23.9

Causes of Death

	MALE	FEMALE	TOTAL
1 Tuberculosis of Respiratory System ...	3	1	4
2 Other forms of Tuberculosis ...	—	—	—
3 Syphilis ...	2	1	3
4 Diphtheria ...	—	—	—
5 Whooping Cough ...	—	—	—
6 Meningococcal Infections ...	—	—	—
7 Acute Poliomyelitis ...	—	—	—
8 Measles ...	—	—	—
9 Other Infective and Parasitic Diseases ...	—	—	—
10 Malignant Neoplasm, Stomach ...	3	3	6
11 " " Lung, Bronchus ...	9	1	10
12 " " Breast ...	—	2	2
13 " " Uterus ..	—	—	—
14 Other Malignant & Lymphatic Neoplasms	14	12	26
15 Leukaemia, Aleukaemia ..	1	—	1
16 Diabetes ...	2	1	3
17 Vascular Lesions of Nervous System ...	18	28	46
18 Coronary Disease, Angina ...	21	17	38
19 Hypertension with Heart Disease ...	8	1	9
20 Other Heart Disease ...	31	50	81
21 Other Circulatory Disease ...	5	1	6
22 Influenza ...	3	3	6
23 Pneumonia ...	6	8	14
24 Bronchitis ...	7	3	10
25 Other Diseases of Respiratory System ...	1	—	1
26 Ulcer of Stomach and Duodenum ...	—	2	2
27 Gastritis, Enteritis and Diarrhoea ...	3	1	4
28 Nephritis and Nephrosis ...	1	1	2
29 Hyperplasia of Prostate ...	—	—	—
30 Pregnancy, Childbirth, Abortion ...	—	—	—
31 Congenital Malformations ...	3	—	3
32 Other Defined and Ill-defined Diseases ...	6	12	18
33 Motor Vehicle Accidents ...	2	—	2
34 All other Accidents ...	3	8	11
35 Suicide ...	1	—	1
36 Homicide and Operations of War ...	—	—	—
	153	156	309

GENERAL PROVISION OF HEALTH SERVICES FOR THE AREA

Public Health Officers of the Authority

Medical Officer of Health:

S. CHALMERS PARRY, M.A., CANTAB., M.R.C.S., L.R.C.P., D.P.H.

Engineer, Surveyor and Chief Public Health Inspector:

F. LINDLEY, M.R.P.H.I., A.M.I.S.E., M.P.H.I.A.

Additional Public Health Inspectors:

H. L. WENDEN, CERT. S.I.B.

H. P. BIRD, CERT. S.I.B.

Administrative Assistant:

D. KNOWLTON, A.C.C.S.

Laboratory Facilities

Bacteriological work is carried out by the Public Health Laboratory at the Royal Hampshire County Hospital, Winchester (Telephone Winchester 3807) and specimens of clinical materials (sputum, swabs, etc.) and samples of water, milk and foodstuffs are sent for bacteriological examination to the Director, Dr. M. H. Hughes.

Specimens may be deposited in the sample box placed outside the Laboratory, or they may be left at the Main Hall of the Hospital at any time when the Laboratory is closed. At weekends, and on public holidays, arrangements are made for dealing with specimens during the morning and evening. *Urgent* specimens can be dealt with at any time and Dr. M. H. Hughes is available at Twyford 3349 for telephone consultations when he is not in the Laboratory.

Some specimens in connection with cases of infectious diseases, which have been admitted to the Portsmouth Infectious Diseases Hospital, are sent for bacteriological examination to Dr. K. Hughes, Director of the Public Health Laboratory, Milton, Portsmouth (Telephone Portsmouth 22331).

At Portsmouth, specimens may be left at the Porter's Lodge of the Infectious Diseases Hospital, at any time. *Urgent* specimens can be dealt with, when the Laboratory is closed, by telephoning the technician on call at St. Mary's Hospital (Portsmouth 22331).

Samples for chemical analysis are sent to the Public Analyst at "Spetchley," Cobden Avenue, Bitterne Park (Telephone, Southampton 55826).

Ambulance Facilities

All applications for the use of ambulances should be directed to the Ambulance Officer, Fareham (Telephone, Fareham 2170) who arranges for the most conveniently situated ambulance to attend.

Hospital Car Service

The use of this service may be obtained through the Ambulance Officer (Telephone Fareham 3626).

Smallpox cases (suspected or confirmed) requiring transport to hospital will be conveyed by the County Ambulance Service by arrangements made through the Beds Admission Office (Telephone, Winchester 2261).

Nursing and Health Visiting in the Homes and Clinics

The names and addresses of District Nurses, Midwives and Health Visitors, who practise in the district under the direction of the County Medical Officer, are shown in the following table :—

<i>Names and addresses of Nurses</i>	<i>District Served</i>	<i>Names of Health Visitors</i>
MISS A. L. BROWN, S.C.M., 18 Penfords Paddock, Bishop's Waltham. (Tel. Bishop's Waltham 199)	Waltham Chase Part of Bishop's Waltham	MISS B. M. WATSON, S.R.N., S.C.M., R.S.H. Certificate * Tel. Bishop's Waltham 107
MISS V. J. BENSON, S.R.N., S.C.M., 14 Folly Field, Bishop's Waltham, (Tel. Bishop's Waltham 330)	Upham Part of Bishop's Waltham	
MRS. M. S. WILLS, S.R.N., S.C.M., 16 Elizabeth Road, Wickham. (Tel. Wickham 2277)	Shedfield (except Waltham Chase) Wickham, Boarhunt other than Curbridge	MISS B. G. M. OSBORN, S.R.N., S.C.M., R.S.H. Certificate Orthopaedic Nursing Certificate * Tel. Portsmouth 31155
MISS A. L. BROWN, S.C.M., 18 Penfords Paddock, Bishop's Waltham, (Tel. Bishop's Waltham 199)	Swanmore	
MRS. K. M. ZOLLO, S.R.N., S.C.M., 2 Bere Road, Denmead. (Tel. Hambledon 649)	Denmead Hambledon Southwick	
MISS V. G. CHADWELL, S.R.N., S.C.M., Q.N., R.S.H. CERT., U.S.A. MID. CERT., 20 The Park, Droxford. (Tel. Droxford 210)	Soberton Droxford Corhampton Meonstoke Exton	MISS V. G. CHADWELL, S.R.N., S.C.M., Q.N., R.S.H. Certificate U.S.A. Mid. Cert. * Tel. Droxford 210
MISS F. R. MOORE, S.C.M., 16 Glenthorne Meadow, East Meon. (Tel. East Meon 263)	Warnford West Meon	MISS E. J. READ, S.R.N., S.C.M., R.S.H. Certificate A.R.San.I. * Tel. West Meon 315
MISS A. L. JOHNSON, S.R.N., S.C.M., 33 Newlease Road, Waterlooville. (Tel. Waterlooville 3607)	Widley	MISS D. V. ALLOWAY, S.R.N., Q.N. R.S.H. Certificate * Tel. W'looville 3516
MISS V. J. BENSON, S.R.N., S.C.M., 14 Folly Field, Bishop's Waltham. (Tel. Bishop's Waltham 330)	Durley	MISS P. JENKINS, S.R.N., S.C.M., R.S.H. Certificate * Tel. Twyford 2021
MISS D. STOYELL, S.C.M., Leehurst, Botley. (Tel. Botley 2015)	Curdrige Curbridge area of Wickham	

* If the services of a Health Visitor are required, please telephone before 9 a.m. or after 5 p.m.

Child Welfare Centres

The following Child Welfare Centres in the Rural District are open for children under five years of age.

<i>Centre</i>	<i>Hall</i>	<i>Afternoons</i>
Bishop's Waltham ...	Youth Club	1st and 3rd Fridays
Denmead ...	Memorial Hall, Main Street	4th Mondays
Droxford ...	Village Hall	1st Mondays
Durley ...	Memorial Hall	2nd Fridays
Hambledon ...	Women's Institute ...	2nd Mondays
Meonstoke ...	The Meon Hut	1st Tuesdays
Southwick ...	Manor Hall	4th Fridays
Swanmore ...	Parish Room	3rd Thursdays
Upham ...	Village Hall	3rd Tuesdays
Waltham Chase	Chase Hut	2nd and 4th Wednesdays
Wickham ...	Victory Hall	1st and 3rd Wednesdays

The following five centres, situate in adjoining districts, are available for children living near the boundaries of the district :—

<i>Centre</i>	<i>Hall</i>	<i>Afternoons</i>
East Meon ...	Institute Hut	1st and 3rd Thursdays
Fair Oak ...	Women's Hall	2nd and 4th Thursdays
Purbrook ...	Deverall Hall	2nd and 4th Wednesdays
Park Gate ...	British Legion Hall ...	2nd and 4th Thursdays
Titchfield ...	Parish Hall	1st and 3rd Mondays

The work of the voluntary helpers, who assist the medical and nursing staff at the welfare centres, is greatly appreciated.

FAMILY PLANNING ASSOCIATION CLINICS

Advice on family planning is given at the following clinics, which are run on a voluntary basis, as the Service is not available under the National Health Service.

A lady doctor and sister are in attendance.

AREA	ADDRESS OF CLINIC	DAY	TIME
Cosham	Child Welfare Centre, Northern Road	Wednesdays	1.30 - 3.30 p.m.
Eastleigh	The Red House, 6 Romsey Road	Fridays	2.0 - 4.0 p.m.
Fareham	County Council Health Clinic, Assembly Hall, West Street	Monday	5.0 - 7.0 p.m.
Gosport	"Rostellan," 2 Stoke Road	Thursdays	5.0 - 7.0 p.m.
Portsmouth	Trafalgar Place, Clive Road, Fratton	Tuesdays Fridays	1.30 - 3.30 p.m. 6.0 - 8.0 p.m.
Winchester	The Hut (adjoining Trafalgar House) Trafalgar Street	Tuesdays	2.0 - 4.0 p.m.

Any further information can be obtained from the County Medical Officer.

It is desirable that a woman should, at her first attendance, take to the Clinic a letter from her own doctor.

***Tuberculosis**

The following Chest Clinics are available to patients suffering from Tuberculosis :—

FAREHAM—The Chest Clinic, St. Christopher's Hospital, Wickham Road
Telephone : Fareham 2263

Wednesday 9.45 a.m. Previous Patients by appointment
2.00 p.m. New Patients
Evening Clinic (2nd in odd month only) by appointment
Thursday 9.45 a.m. Previous Patients by appointment
2.00 p.m. A.P. Refills (weekly)
Chest Physician—Dr. J. Butterworth

HAVANT—The Chest Clinic, Queen Alexandra Hospital
Telephone : Cosham 79451 Extension 58

Monday 10.00 a.m. Previous Patients
2.00 p.m. Previous Patients
Wednesday 2.00 p.m. New Patients
Thursday 2.00 p.m. A.P. Refills (weekly)
5.00 p.m. By appointment (2nd in month only)
Chest Physician—Dr. J. P. Sharp

WINCHESTER—County Medical Department, Trafalgar Street
Telephone : Winchester 4411 Extension 132

Wednesday 10.00 a.m. Previous Patients
2.30 p.m. New Patients
Thursday 9.30 a.m. By appointment
1.30 p.m. A.P. Refills at Royal Hampshire County Hospital
Chest Physician—Dr. A. Capes

EASTLEIGH—The Mount Sanatorium, Bishopstoke
Telephone : Eastleigh 2335

Monday 9.30 a.m. Previous Patients
2.00 p.m. New Patients by appointment
Evening Clinics (every 1st Monday only) by appointment
Wednesday 10.00 a.m. A.P. Refills
2.00 p.m. Previous Patients
Friday 2.00 p.m. 1st only—BCG for children
Chest Physicians—Dr. A. Capes
Dr. D. C. Lillie

*Venereal Diseases

Treatment is available at the following Clinics :—

PORTSMOUTH—St. Mary's Hospital

Males : 10 a.m. to 12 noon, and 5 p.m. to 7 p.m.
Tuesdays and Thursdays

Females : 5 p.m. to 7 p.m., Mondays
2 p.m. to 4 p.m., Wednesdays
10 a.m. to 12 noon, Fridays

SOUTHAMPTON—1 Cardigan Road (off New Road)

Males : 9 a.m. to 12 noon, and 5 p.m. to 7 p.m.
Mondays, Tuesdays, Wednesdays, Thursdays and
Fridays
9 a.m. to 12 noon, Saturdays

SOUTHAMPTON—Health Centre, King's Park Road

Females : 10 a.m. to 12 noon, Mondays
2 p.m. to 4 p.m., Tuesdays
3 p.m. to 5 p.m., Thursdays
2 p.m. to 4 p.m., Fridays

WINCHESTER—Royal Hampshire County Hospital

Males : 10.30 a.m. to 12 noon, Saturdays
Females : 2.15 p.m. to 4. p.m., Tuesdays

SCHOOL HEALTH SERVICES

*Orthopaedic Clinics

Orthopaedic cases, requiring treatment, are seen *by appointment* from the Appointments Officer at each Hospital, at the following Clinics :—

Alton *Surgeon's Clinic*, held at Lord Mayor Treloar
Hospital on Fridays
Remedial Clinic, held at Lord Mayor Treloar
Hospital daily

Winchester *Surgeon's Clinic*, held at the Royal Hampshire
County Hospital, 1st Friday each month p.m.
Remedial Clinic, held at the Royal Hampshire
County Hospital daily

Fareham	<p><i>Surgeon's Clinic</i>, held at St. Christopher's Hospital, on Wednesday a.m. every 4th week</p> <p><i>Minor Clinic</i>, held at the County Health Clinic, West Street, as required, by appointment with the County Medical Officer</p> <p><i>Remedial Clinic</i>, held at St. Christopher's Hospital, on Mondays and Thursdays all day</p>
Havant	<p><i>Surgeon's Clinic</i>, held at Havant War Memorial Hospital on 4th Tuesdays, p.m.</p> <p><i>Remedial Clinic</i>, held at Health Clinic, 4 Park Way on Tuesdays, all day (except 4th Tuesday) and Wednesdays all day</p>
Petersfield	<p><i>Remedial Clinic</i>, held at Petersfield General Hospital, as required</p>

***Ear, Nose and Throat Clinics**

Cases, referred for specialist advice, are examined at the Portsmouth Eye and Ear Hospital or Winchester Royal Hampshire County Hospital, and treatment is carried out there or at Petersfield.

***Ophthalmic Clinics**

These are available, *by appointment*, through the County Medical Officer, at the following places :—

Winchester	<p>Held at Trafalgar House— 1st and 4th Mondays all day, 2nd Monday p.m.</p>
Havant	<p>Held at County Council Clinic, Park Way— every Monday a.m. only</p>
Fareham	<p>Held at St. Christopher's Hospital— 1st and 3rd Tuesdays all day</p>
Petersfield	<p>Held at County Council Health Clinic, Love Lane— 2nd Tuesdays, p.m. only</p>

***Orthoptic Clinics**

Cases, selected by the School Oculist, are referred to the Eye and Ear Hospital, Portsmouth

Speech Therapy Clinics

Cases attend, *by appointment*, at the following centres :—

Winchester Health Clinic, Trafalgar House, every Monday and Tuesday at 9.30 a.m. and Friday at 9.30 a.m. and 1.30 p.m.

Fareham Health Clinic, The Assembly Hall, every Monday and Thursday at 9.30 a.m. and 1.30 p.m. and Tuesday at 9.30 a.m.

Havant County Council Health Clinic, on Wednesdays and Thursdays at 9.30 a.m. and 1.30 p.m.

Child Guidance Clinic

Cases are seen, *by appointment*, at Trafalgar House, Winchester Psychiatric Out-patient Clinic—Monday, Tuesday, Wednesday and Friday, at 2.30 p.m. at Knowle Hospital. Wickham 2271

Dental Clinics

These are held, when required, for school children, pre-school children and expectant and nursing mothers *by appointment* at :—

County Council Health Clinic, Love Lane, Petersfield
(Telephone, Petersfield 20, between 9 a.m. and 9.15 a.m. for appointments)

County Council Health Clinic, Park Way, Havant
(Telephone, Havant 716)

4 The Square, Winchester
(Telephone, Winchester 3347)

County Council Health Clinic, The Assembly Hall, off West Street, Fareham
(Telephone, Fareham 2937)

Dental Clinic, Chamberlayne Road, Eastleigh
(Telephone, Eastleigh 2498)

The Manor School, Portchester
(Telephone, Winchester 4411 Extension 102)

Also at other premises and schools as and when required

* *These services are the responsibility of the Regional Hospital Board*

List of Clinics most accessible to each Parish

PARISHES	Child Welfare	Chest	Orthopaedic	Ear, Nose and Throat	Eye	Speech	Dental
Bishop's Waltham ...	Bishop's Waltham	Winchester Fareham	Winchester Fareham	Winchester	Winchester Fareham	Winchester Fareham	Winchester Fareham
Boarhunt ...	Southwick Wickham	Fareham	Fareham	Portsmouth	Fareham	Fareham	Fareham
Corhampton & Meonstoke	Meonstoke	Fareham	Petersfield Fareham	Portsmouth	Petersfield Fareham	Petersfield	Petersfield Fareham
Curdridge ...	Waltham Chase	Fareham Eastleigh	Fareham	Winchester	Fareham	Fareham	Eastleigh
Denmead ...	Denmead	Cosham	Havant	Portsmouth	Havant	Havant	Havant
Droxford ...	Droxford	Fareham	Fareham	Portsmouth	Fareham	Fareham	Fareham
Durley ...	Durley	Eastleigh	Eastleigh	Winchester	Winchester	Winchester	Eastleigh
Exton ...	Meonstoke	Fareham	Petersfield Fareham	Winchester Portsmouth	Petersfield Fareham	Petersfield	Petersfield Fareham
Hambleton ...	Hambleton	Cosham	Havant	Portsmouth	Havant	Havant	Havant
Shedfield ...	Waltham Chase	Fareham	Fareham	Winchester Portsmouth	Fareham	Fareham	Fareham
Soberton ...	Droxford	Fareham	Fareham	Portsmouth	Fareham	Fareham	Fareham
Southwick & Widley	Southwick	Fareham	Fareham	Portsmouth	Fareham	Fareham	Portchester
Swanmore ...	Swanmore	Fareham	Fareham	Winchester	Fareham	Fareham	Fareham
Upham ...	Bishop's Waltham Fair Oak	Winchester	Winchester	Winchester	Winchester	Winchester	Eastleigh
Warnford ...	East Meon Meonstoke	Winchester	Petersfield	Winchester	Petersfield	Petersfield	Petersfield
West Meon ...	East Meon	Winchester	Petersfield	Winchester	Petersfield	Petersfield	Petersfield
Wickham ...	Wickham Titchfield Park Gate	Fareham	Fareham	Portsmouth	Fareham	Fareham	Fareham

HOSPITALS

General

There are no General Hospitals within the district, but the following hospitals are available :—

THE ROYAL SOUTH HANTS HOSPITAL, SOUTHAMPTON
(Telephone : Southampton 26211)

CHILDREN'S HOSPITAL, SOUTHAMPTON
(Telephone : Southampton 71012)

THE ROYAL HAMPSHIRE COUNTY HOSPITAL, WINCHESTER
(Telephone : Winchester 5151)

THE ROYAL PORTSMOUTH HOSPITAL, PORTSMOUTH
(Telephone : Portsmouth 22281)

ST. MARY'S HOSPITAL, PORTSMOUTH
(Telephone : Portsmouth 22331)

Knowle Hospital (Wickham 2271), situated at Knowle in the Parish of Wickham, is administered by the Regional Hospital Board, Portsmouth. Kitnocks House, Curdridge (Telephone, Botley 2553), and Corhampton House, Corhampton (Telephone, Droxford 20), which provide accommodation for old people from all parts of the county, are under the control of the County Council.

Infectious Diseases

There is no infectious diseases hospital in the district.

Any Infectious Diseases Hospital is available for the admission of cases occurring in the district. Patients are generally admitted to the Portsmouth Infectious Diseases Hospital, Milton Road (Telephone, Portsmouth 22331), or to the Victoria Isolation Hospital, Morn Hill, Winchester (Telephone, Winchester 2048), or Southampton Chest Hospital (Pavilion "A") Oakley Road, Southampton (Telephone, Southampton 71042), which are under the control of the Regional Hospital Board.

Special arrangements have been made for the admission of children suffering from acute poliomyelitis to Lord Mayor Treloar Hospital, Alton (Telephone Alton 2811).

Sanatoria

Sanatoria for patients, suffering from Tuberculosis, are provided by the Regional Hospital Board.

Smallpox

The Regional Hospital Board makes provision for the treatment of cases of smallpox at Crabwood Smallpox Hospital.

The Beds Admission Office (Telephone, Winchester 2261) deals with the admission of these patients.

PREVENTIVE MEASURES

FOOD HYGIENE

The communal way of feeding, which was forced upon many folk during the war years, is still widely practised and, because of their cheapness, made-up meat dishes remain very popular. These circumstances have, no doubt, contributed to the prevalence of food poisoning caused by the infection of pre-cooked food.

So it should constantly be borne in mind by all concerned in the handling, preparation and storage of food—particularly by those who work in canteens or who serve food to large numbers—that the utmost care must be taken to obviate the risk of food poisoning, which may occur even in the best equipped canteen.

Any food handler should report to his employer if he is suffering from any of the following conditions :—

- (1) Diarrhoea or vomiting
- (2) Septic cuts or sores, boils or whitlows
- (3) Discharges from the ear, eye or nose
- (4) Any feverish illness

Customers have now become more clean food minded ; and, if any uncleanness is observed in food premises, they often complain to the management.

The hygiene standard of such shops and restaurants therefore lies to some extent in their hands.

A high standard of hygiene is a benefit to food traders, for it attracts business ; and it is of course all in the interest of the general public to encourage safer practices.

The washing of hands immediately after using the toilet is absolutely essential for everybody, for toilet paper is porous ; and, once contaminated, the hands will leave bacteria behind on everything they touch. “No touch” technique should be practised by all food handlers.

Cakes, boiled sweets, cooked food and *vulnerable foods* should be handled by tongs or servers and not fingered by the hands, for they are never clean enough safely to handle food of this nature.

Vulnerable foods—which include pressed meat, brawn, meat-pies, stews, trifles, custards and synthetic cream—are normally quite safe when prepared, but they act as ideal breeding grounds for any dangerous germs that gain access, and, if kept at warm temperatures, the germs will multiply very rapidly.

Made up meat dishes and other vulnerable foods provide a perfect medium for the growth and multiplication of bacteria.

The ordinary group of food poisoning organisms, (i.e. the *Salmonellæ*) are killed by heating, but the fact that they occur in a product, which is going to be heat treated, is no absolute safeguard against any spread—as the infection is often carried from the raw material on the hands and utensils to some article of food in the same premises, which is either already cooked or not subject to heat treatment.

There is, however, another type of germ that is not killed by heat and does not even require the presence of air for it to produce its toxins if the temperature conditions are suitable and the intervals of time between the end of cooking and the consumption of food is sufficiently long.

This organism is not uncommonly found in meat, so the sooner meat is eaten after cooking, the less likelihood there is for cases of food poisoning from this source of infection to occur. In fact, if all meat were eaten on the day it was cooked, these outbreaks would cease. Soups, stews, gravies, pies, pease pudding, etc., provide even better conditions for the multiplication of the germs than solid meat.

A high standard of hygiene for food traders is best obtained by observing the following simple rules :—

- (1) Protection of food from all sources of contamination (dust and droplet infection as well as from flies, cock-roaches' rats and mice).
- (2) Personal cleanliness of "food non-handlers."
- (3) Proper storage and display of food at safe temperature.

The most recent report from the Public Health Laboratory Service on Food Poisoning in England and Wales, 1957, states :—
"Good hygiene and the exclusion from food handling of persons with septic lesions on the skin will not by themselves ensure the safety of such frequently implicated food as brawn, pressed meats, ham and bacon, the additional measure is refrigeration."

But emphasis should rightly be placed on methods of preventing the food from becoming contaminated in the first place.

Many outbreaks of bacterial food poisoning would never have occurred if the food, after being cooked, had been rapidly cooled and then placed in a refrigerator until actually required, instead of being left at room temperature overnight and then eaten cold, or warmed up the next day.

Refrigeration conserves food in a wholesome and palatable condition and definitely retards the growth of bacteria if they are present.

It is, therefore, most important that vulnerable food should be stored at a low temperature in a refrigerator or a cool larder to prevent the germs from multiplying.

The food must be at certain temperature and moisture conditions over a period of time before the food poisoning organisms will multiply and produce food poisoning.

The Chief Medical Officer to the Ministry of Health has stated :—

“The remedy is largely in the hands of caterers. The general public can do little in the matter except by way of complaint, for they are not individually aware of what goes on in the kitchens of the establishments they patronise. Nowadays there is little excuse for unhygienic practice in the preparation and serving of food ; the risks are well known and the simple methods by which they may be avoided are within the reach of all. That they are not practised is a direct reflection upon the managements responsible.”

In this connection, the Health Department would be glad to receive complaints from the general public of unhygienic methods practised in any food shops.

The Food Hygiene Regulations, 1955, affect the owner or manager of any “food business” as well as anyone concerned in the actual selling or putting on sale, preparation, transport, packaging, wrapping, service or delivery of food.

HEALTH EDUCATION

The Central Council for Health Education has continued to keep this Department informed of all their up-to-date posters and pamphlets.

The Chief Medical Officer in a report to the Ministry of Health stated :—“The principal source of infection is still the made-up meat dish, which is dangerous, because of the time which elapses between its preparation and consumption.”

It is encouraging to be able to show that for the second year in succession, there has been a drop in the reported incidence of food poisoning, after, as will be seen from the table below, a steady increase in the previous five years.

Food Poisoning Statistics, 1951-57

(from reports of Public Health Lab. Service)

	<i>Outbreaks</i>	<i>Family Outbreaks</i>	<i>Sporadic Cases</i>	<i>Total Incidents</i>
1951	343	287	2,717	3,347
1952	372	340	2,807	3,519
1953	492	422	4,363	5,377
1954	506	630	4,880	6,016
1955	612	723	7,626	8,961
1956	563	616	6,534	7,713
1957	473	501	6,097	7,071

“For the first time, no outbreaks associated with milk were reported.”

This improvement may well reflect results of some of the good health education that there has been on this subject. But much of this poisoning is preventable, and it is clear from figures of the thousands of incidents (representing many more thousands of people affected) that more education is needed.

Egg products are possibly one of the main sources of salmonellæ in foods and it is possible that, if egg and egg products, meat and meat products, and feeding stuffs and fertilizers could be protected from contamination with salmonellæ in the first place, or if all products likely to be contaminated with salmonellæ could be adequately heat-treated, the incidence of food poisoning would fall considerably.

Whilst latest food hygiene regulations may help to decrease food poisoning due to organisms other than salmonellæ, there will be little difference in the general picture so long as the distribution of contaminated food stuffs is allowed to continue.

Authorities state there is no evidence to show that food poisoning organisms are present in the flora of newly caught fish or that fish suffer from salmonellæ infections; but the situation is quite different with poultry or meat. Salmonellæ are often present in the intestines of both diseased and healthy animals. The infection may easily be spread in slaughterhouses and food shops or kitchens by dogs, cats, rats, mice or even pigeons, as each of these species may carry the germ. But infection of beef and beef products appears to occur more frequently after slaughter and possibly after the meat has left the slaughterhouse.

Prevention of salmonellæ food poisoning depends on knowing more of the potential sources of contamination and is a long term problem ; otherwise the remedies for the elimination of food poisoning are simple and can easily be applied. From the continued high incidence of food poisoning, however, it is evident that certain caterers still find difficulty in applying them."

In order to encourage good habits of personal hygiene among members of the staff of catering establishments, housewives and others, the Ministry of Health has prepared several good posters on the subject, including four illustrated coloured posters, which cover the four essentials of good food handling :—

- (1) " Wash your hands well "
- (2) " Finger food as little as possible "
- (3) " Cover all cuts and sores properly "
- (4) " Cover food against flies "

The seeds of good hygiene are sown at home, but if they are germinate and develop successfully, cultivation must be encouraged at school.

Children have gradually become more used to modern methods of sanitation and it is unfortunate that these are not always available in school buildings.

SMOKING AND CANCER OF THE LUNG

In 1957, the Ministry of Health sent a circular to all local health authorities on the subject of smoking and lung cancer. In that circular, it was stated that the Medical Research Council had concluded that the most reasonable interpretation of the very great increase in deaths from lung cancer in males during the past 25 years was that a major part of it was caused by smoking tobacco, particularly cigarette smoking.

These authorities were asked to make known the risks through their arrangements for health education so that everyone may be aware of the risks involved in smoking, and the individual who smokes can then make up his or her own mind.

To smoke or not to smoke ? that is the burning question for all those from adolescence to middle-age.

At the request of the Ministry of Education, greater attention is now paid to the problem of cigarette smoking among children. They are encouraged to think very carefully before commencing the practice which may become a habit associated with the increased incidence of lung cancer in later life. The County Medical Officer says "It behoves all doctors, particularly those interested in preventive medicine, to lose no opportunity of keeping the public aware of this danger, and especially to dissuade the younger age groups from acquiring the smoking habit."

Dr. Horace Joules, a chest physician, summarises the position as follows :—

"In Britain, we suffer more from bronchitis than any other country in the world and the cigarette is one of the main causes for this high incidence. We led the world in cigarette smoking from about 1910 to 1930 and now we lead the world with our figures for bronchitis and cancer of the lung.

In many countries, scientific study has shown that the rise in cases of cancer of the lung is directly related to the rise in cigarette smoking, but this result follows at least 25 years of smoking—except in the very heavy smoker. At least four out of five cases of cancer of the lung are caused by the habit."

Dr. J. H. Edwards estimates that, in 1957, the total number of deaths caused from tobacco—i.e. by lung cancer, bronchitis and reactivated pulmonary tuberculosis—was nearly five times as heavy as deaths on the roads.

Dr. J. A. Scott, Medical Officer of Health to the County of London, states :—"The people most likely to benefit by anti-smoking propaganda fall into three groups—school children, adolescents and those in early middle and middle age.

A principal difficulty with young people is that, in their own estimate, they are immortal, and the possibility of any event happening more than a month or two ahead will not affect their present conduct. They are, however, extremely susceptible to influence by example.

Much can be done by the example of parents and teachers, elder brothers and sisters and others whom small children watch and imitate. And the most effective method is for them to use self-discipline and not smoke themselves, because children accept, as normal and desirable, the standards of conduct of their elders.

Adolescents are recognised as the main target for direct approach. They have an increasing sense of self-importance, recently acquired, which needs to be reinforced by assuming the habits and manners of maturity. And what is more important, their example is not lost upon their younger brothers and sisters."

ACCIDENTS IN THE HOME

More people are killed by accidents in the home than by accidents on the road, the fact is not really surprising since people spend much more time in their houses ; but it does mean that we must do everything we can to reduce home accidents.

Over 6,000 persons die annually in England and Wales as a result of accidents in their homes. Most fatalities result from four main causes—falls, poisoning, burns and scalds and suffocation, and of these, about 700 are due to burns and scalds.

More than four-fifths of the fatalities concern the young and the old, and as high a proportion as two-thirds involve infants under one year and elderly people of seventy-five and over who are prone to falls, gas poisoning and burns. The majority of home accidents are preventable.

Accidents to Children

According to the Chief Medical Officer's report to the Ministry of Health, during the year, 733 children, including 637 under five years of age, suffered fatal accidents in their homes. This figure of 733 fatalities, which forms 11% of all fatal domestic accidents is, happily, the lowest figure yet recorded, but most burns and scalds and poisoning accidents to children must be regarded as preventable.

These must be attributed mainly to inadequate supervision ; but carelessness, thoughtlessness, apathy and lack of knowledge of the adults in charge all play their part. Women and girls suffer more than twice as many burning accidents as men and boys, for full skirted loose garments present a much greater fire risk than narrow or close fitting ones.

Occasionally children have been found suffocated by *plastic* bibs or bags.

The U.S. National Safety Council reported 28 fatalities from plastic "garment bags" between January and June.

It seems that the plastic bag becomes electrically charged and, if pulled over a child's head, it clings tenaciously and resists removal.

If a small child is found dead with a plastic bib firmly plastered over his face, the adhesive qualities of saliva and food remnants around the baby's mouth are generally blamed. But now the electrical properties of the bib may be called in question.

Plastic bibs should always be secured to the baby's clothes to prevent disaster ; and small children should not be allowed to play with plastic bags or they may use them as "space helmets" etc. Plastic bags must be regarded as potentially lethal to young children.

Accidents in Old People

The accident rate is high in old people. With increase in age physical and mental deterioration may reduce the capacity to co-ordinate thought and action. Some old people become fatigued, forgetful or absent-minded, and these psychological features may be accompanied by physiological changes, failing vision, impaired hearing and sense of smell, and muscular weakness ; and the infirm and the handicapped are liable to accidents through inexpert handling of heating and lighting appliances and inability to avoid obvious hazards. Falls account for nearly two-thirds of fatal home accidents and three-quarters of these fatalities affect people of seventy-five and over.

The majority of the victims are women.

Thermal Accidents

Statistics about non-fatal accidents are not available, but it is estimated that each year not less than 50,000 persons need hospital treatment for burns and scalds caused by domestic accidents and that about 80% of the deaths, resulting from extensive burns, are due to clothing catching on fire. Most of these accidents are due to the clothing coming in contact with the heating element or flame of an unguarded or inadequately guarded coal, gas, electric or oil heating appliance. "Open" fires are responsible for more fatal accidents than any other type.

Scalds have a much lower death rate than burns, but the incidence nearly equals that of burns and the degree of disfigurement or disablement may be equally severe. They occur most commonly in children under five years of age, and the most serious accidents result from children falling into buckets or basins of hot water placed on the floor. They may also be caused by children pulling over themselves vessels, saucepans or pans containing hot fluids or fat or by pulling the flexes of electric kettles.

Approximately two-thirds of the hospital admissions for scalds' sustained at home, occur in children under five years of age.

Preventive Measures

The majority of these burning and scalding accidents could be avoided and, in spite of the publicity that has been given to the subject during recent years, the position has not much improved.

While propaganda of all kinds plays a valuable part in prevention, it is the personal contact of doctors, nurses and social workers with the people in their homes that is likely to bring the most rewarding results.

Under the Children and Young Persons Acts, 1933 and 1952, parents and guardians are liable to a fine if a child of 12 years or under is seriously injured from burns caused by an unguarded "heating appliance liable to cause injury to a person by contact therewith."

The Heating Appliances (Fireguards) Act, 1952, and the Regulations made under it require that, from 1st October, 1954, all gas, electric and oil fires must be fitted, when sold, with a guard attached. Many householders are not aware of the danger of unguarded fires, have no knowledge of this Act, and have taken no steps to acquire guards for the fires purchased before the Regulations came into force.

Efficient Fireguard

The most effective simple way of reducing the number of serious burning accidents is by the use of the properly designed and fixed fireguard of the British Standard Specification. It forms a protection from burning by falling into an open fire, by children tampering with one, or by clothing accidentally brushing against a fire.

Safer Clothing

The most frequent cause of serious burns is clothing catching alight. The provision of fireguards for all types of fires and the choice of safer garments for women and children to wear will reduce these accidents. The flammable nature of nearly all fabrics currently in use makes the guarding of fires doubly important. Pyjamas are much safer than night-dresses, particularly for children. Full skirted party dresses and other loose flimsy garments also require special caution.

Recent research has shown that virtually all fabrics in common use for clothing are flammable and that the shape of the garment and the nature of the source of ignition are the most important factors in relation to accident risk.

A special Committee was set up by the British Standards Institution to consider the flammability rating of clothing textiles. In their report * they recommended that a standard of durable flame-resistance of fabrics should be established, and that goods offered for sale to the public as flame resistant, should be warranted as such and identified accordingly.

Care is necessary with all fabrics which are now known to be flame-resistant; and the public should be encouraged to obtain fabrics which comply with the British Standard of "flame-resistance" as soon as these become available.

Prevention of Scalding Accidents

Overcrowding is frequently a contributory factor, and the kitchen is the most dangerous room. There is no doubt that kitchen discipline and kitchen design could do much to reduce the incidence of scalds. The cooker and the sink should not be on opposite sides of the room, but should be sited along one wall, or two adjacent walls, and joined by a work surface.

Although, in some cases, scalding accidents may be precipitated by the shape, design and use made of the kitchen or by the form of domestic equipment, it is nevertheless clear that the majority of incidents are due to carelessness.

While the final responsibility for the prevention of burns and scalds in the home must rest with the householder, every authority, organisation and individual has something to contribute to the provision of safety in the home and it is only by the combined efforts of everyone that the incidence of burns and scalds can be reduced.

Local Campaign

In November, a national "Guard that Fire" Campaign was opened by the Home Secretary. The aim of the campaign was to persuade householders to guard all fires, whether coal, gas or electric.

Considerable publicity for the campaign was organised locally and posters and propaganda material were distributed throughout the district; posters were affixed to Council vehicles and fireguard fittings were installed in Council houses where requested by the tenant.

It would appear that this campaign was a success.

* The Flammability of Apparel Fabrics in relation to Domestic Burning Accidents by British Standards Institution 1957, Accidents in the Home—Burns and Scalds (Ministry of Health).

INTERNATIONAL TRAVEL

Travellers from abroad, who may have been contacts of small-pox or other dangerous diseases while out of this country, are required to show their doctors notices issued to them on arrival at airports in the event of their becoming ill during the succeeding 21 days.

Passengers undertaking international travel must be in possession of certain vaccination certificates, depending upon the place of departure, the countries of transit and the destination. International certificates are issued in connection with small-pox, yellow fever and cholera.

The International Sanitary Regulations, 1956, specify the following periods for the validity of international certificates of vaccination.

<i>Type of Vaccination</i>	<i>Validity (after date of vaccination or inoculations)</i>	
	<i>Begins</i>	<i>Ends</i>
Smallpox—primary vaccination	- - 8 days	3 years
Smallpox—re-vaccination	- - At once	3 years
Cholera—primary vaccination	- - 6 days	6 months
Cholera—re-vaccination within six months	- At once	6 months
Yellow Fever—primary vaccination	- - 10 days	6 years
Yellow Fever—re-vaccination within six years	At once	6 years

But the health authorities of some countries vary these periods and details of immunisation requirements can be obtained from the airline or steamship company concerned, or from the Consulates of the countries to be visited.

Persons who are required to be vaccinated or inoculated against more than one disease are advised to tell the doctor of all the vaccinations or inoculations needed as they may have to be done in a particular order with certain minimum intervals.

The vaccinations must be recorded on the international vaccination certificate form prescribed by the World Health Organisation, dated and signed by the doctor doing the inoculation and, in the case of smallpox and cholera, authenticated and stamped by the Health Department of the district.

The international certificate forms must be obtained by the traveller himself from the travel agency or Ministry of Health, except those for yellow fever which are held at certain recognised centres where the vaccination is performed.

In this area, yellow fever vaccinations are carried out at the Pathological Laboratory of the Royal South Hants and Southampton^U Hospital, Exmoor Road, Southampton, on Tuesdays by appointment (Telephone : Southampton 26211).

For inoculations where no international certificate is required, an ordinary certificate by the doctor is sufficient.

SMALLPOX VACCINATION

The speed of air travel makes the task of preventing the imported case of smallpox particularly difficult ; so the earliest possible detection of the disease is of the utmost importance in preventing the spread.

Outbreaks of smallpox in this country generally arise from the importation of the disease from abroad, and this was so in 1957. It is something of a paradox that the application of preventative measures, so easily and fully available, should in a great many instances have to await the occurrence of the very condition they are designed to prevent before advantage is taken of them.

In England and Wales in 1956, the percentage of infants under the age of one year, who were vaccinated, was only 38.4 and the figure for 1957 was 43.0. It is still far below what may be regarded as satisfactory. This low acceptance rate and the resulting lack of protection to the individual and the community is causing much concern ; the aim should be to see that every healthy infant is vaccinated—not only because routine infant vaccination is thought to be justified as the first step in establishing a satisfactory immunity in later years, but also on account of the immediate protection thereby conferred, and the occurrence of outbreaks of imported smallpox from time to time only confirms that the extent of immunity against this disease is not sufficient to prevent an epidemic.

It is therefore important that primary vaccination should be carried out ; it is far too frequently refused because parents are under the impression that it will harm their babies. If the *first vaccination* is put off until adolescence or later, there may be a slight risk ; but it is believed that the risks attending primary vaccination are less in infancy than at any other age and, since many persons will need to be vaccinated at some time, it is highly desirable that this should be done early in life—if only as an insurance against possible untoward effects of vaccination later on.

“ Smallpox is no longer endemic in Europe and the chance of the individual stay-at-home Englishman ever encountering it may be remote, but not everyone remains at home and vaccination is often a pre-requisite for travel or for entry into many countries, as well as an essential personal protection in those areas in which smallpox is endemic. It is necessary in certain types of employment within this country and obligatory for service with the Armed Forces.

So, the probability is that for one reason or another a substantial number of residents in this country will find it desirable to be vaccinated on some occasion during their lives.

The ideal time for the first vaccination is during the first six months of infancy—preferably about the third month.

The "acceptance" rates for infant vaccinations vary considerably in different parts of the country. In this district, the percentage of children under the age of one year, who were vaccinated, was 51%.

The susceptibility of the community as a whole to epidemic smallpox of either the mild or the severe variety cannot be greatly diminished by routine infant vaccination alone. To guard against the social disruption and economic loss which invariably results from the rapid spread of any form of smallpox, it is necessary for the re-vaccination of school children as well as vaccination of infants to be done as a routine.

The re-vaccination of children within two or three years of first entering school not only maintains or revives their individual protection, but is likely to facilitate substantially the control of local outbreaks of smallpox. It also ensures that any further vaccination in later life will be less likely to have any serious reactions or complications.

Re-vaccination carried out at school age, is practically trouble free; and this procedure, done as a routine at least once on all children primarily vaccinated in infancy, would substantially diminish the chance of rapid spread of smallpox.

During the year, 290 vaccinations against smallpox were carried out.

<i>Vaccination</i>	<i>Pre-School Children</i>		<i>School Children</i>		<i>Over 15 years of age</i>
Primary	193	-	3	-	10
Re-vaccination	4	-	15	-	65
Total	197	-	18	-	75

DIPHTHERIA IMMUNISATION

The following information has been based on reports from the Ministry of Health and Registrar General and on pamphlets issued by the Central Council for Health Education

During the year, in England and Wales, there were some small outbreaks of diphtheria and a number of sporadic cases in different parts of the country, which brought the total number of notifications above that for 1957. This is the first time there has been a rise in the incidence of diphtheria for 14 years.

Since 1943, when the Immunisation Campaign got well under way, each year has shown a drop in the number of cases. In 1957, there were only 37 instead of the average 50,000 a year that occurred before the campaign started. Although complete eradication of the disease from an area where cases occur endemically is not an easy matter, there is evidence that there are good prospects of maintaining freedom once it had been gained.

Experience over the last few years has shown that in school communities, where immunisation rates are low, diphtheria infection when once introduced can gain momentum and lead to an outbreak. The need for early immunisation and for the booster dose is therefore stressed.

A more complete protection in the under 5 age group would soon cause a reduced incidence in the early school (5-9) age group and the disease might well be almost eliminated. Only if an adequate level of immunisation is maintained can diphtheria be driven altogether from this country.

The great majority of parents nowadays have never seen or heard of a case of diphtheria among their neighbours' children and are more afraid of illnesses they know than of the dangers of diphtheria.

If parents leave their children unprotected, there may well be other outbreaks.

Although the number of immunisations given to babies under 1 year has decreased only very slightly, the number of "booster" doses for school children has dropped considerably over the past few years.

Complacency, resulting from what has already been achieved, or loss of interest or of confidence in immunisation, may mean that diphtheria will go on occurring endemically and epidemically in this country indefinitely, with the ever-present risk of a return to high mortality; but a vigorously continued immunisation programme, combined with existing methods of epidemic control may free us entirely from the disease except the occasionally imported case.

The Ministry of Health recommends that all children should be immunised before their first birthday—preferably at the age of seven or eight months and that they should receive a “booster” or re-inforcing dose just before entering school, and again every four or five years throughout school life.

Owing to the fact that immunity against diphtheria takes several weeks to develop, those who have been inoculated earlier in life will have the advantage of receiving protection against diphtheria at short notice.

It is therefore, of the utmost importance for parents to realise that active immunisation in the first year of life and re-inforcing doses of prophylactic in later years are just as necessary in the absence of diphtheria epidemics as in their presence.

Immunisation helps the body to build up natural defences against the disease and gives almost certain protection against death from diphtheria.

Resistance to diphtheria is rather like a car battery that needs topping up to maintain its full efficiency. So children should be immunised in the first year of life and have their first “topping-up” before reaching school age.

In this district 48% of the children, born during the year 1957, were immunised before they attained the age of one year. Although children up to five years of age are the most susceptible age group all under fifteen years should be immunised.

During the year, 458 immunisation against diphtheria were carried out :—

Immunisation	Pre-School Children	School Children
Primary	5	1
Re-inforcing or “Boosters” ...	8	42
Combined Primary ...	33	7
Combined “Booster”	6	31
Combined “Booster” Diphtheria & Tetanus	2	6
Triple Primary ...	285	10
Triple “Booster” ...	12	10
Total	351	107

The following tables give the annual incidence and mortality from diphtheria since 1941 :—

		1941	1942	1943	1944	1945	1946	1947	1948	1949
Cases	...	3	—	4	1	2	1	—	—	—
Deaths	...	—	—	—	—	—	—	—	—	—
		1950	1951	1952	1953	1954	1955	1956	1957	1958
Cases	...	—	—	1	—	—	—	—	—	—
Deaths	...	—	—	—	—	—	—	—	—	—

It is satisfactory to record that there have been no deaths from diphtheria since the Council's scheme for diphtheria immunisation by general practitioners in this district commenced in 1935.

WHOOPIING-COUGH IMMUNISATION

This Council was the first Council in Hampshire and, indeed, one of the first in the country, to adopt a Whooping-Cough Immunisation Scheme. The Council's Scheme for Whooping-Cough Immunisation by general practitioners was commenced in 1942.

At the beginning of 1955, the Hampshire County Council's Scheme for Whooping-Cough Immunisation began operating throughout the whole of Hampshire.

The scheme includes combined immunisation against Whooping-Cough and Diphtheria, triple immunisation against Whooping-Cough, Diphtheria and Tetanus and immunisation against Whooping-Cough alone; but it does not provide for the immunisation against Whooping-Cough alone after the age of five years.

Combined Whooping-Cough and Diphtheria immunisation with or without Tetanus is often preferred for the primary immunisation of young children, so as to reduce the total number of inoculations needed for immunisation against three infections.

The final report of the Whooping-Cough Immunisation Committee of the Medical Research Council, designed to test the effectiveness of newer vaccines, confirmed that combined diphtheria-pertussis vaccine was as effective as the pertussis vaccine alone.

The Medical Research Committee concluded that pertussis vaccines, which come up to the required standard, will produce "substantial protection" against the disease.

In general, a reduction of about 10% in the uninoculated (or a 90% protection) may be expected.

But it will be appreciated that the problems of diagnosing an attack of Whooping-Cough, much modified by immunisation, are already common and troublesome in general practice.

While Diphtheria Immunisation has been commenced generally at the seventh or eighth month, Whooping Cough Immunisation is usually started much earlier—at about the third or fourth month of infancy—and, according to authorities, there is no reason why Diphtheria Immunisation also should not be done at an earlier age.

During the year, 396 immunisations against Whooping-Cough were carried out :—

Immunisation	Pre-School Children	School Children
Primary	2	—
Re-inforcing or "Boosters" ...	—	—
Combined Primary ...	33	7
Combined "Booster"	6	31
Triple Primary ...	285	10
Triple "Booster" ...	12	10
Total	338	58

POLIOMYELITIS VACCINATION

In May, 1956, the County Council's Scheme for Poliomyelitis Vaccination of children, born in the years 1947-54, began in selected areas of Hampshire.

Later, in 1957 and 1958, the age groups for registration were extended and the vaccinations were carried out as supplies of vaccine became available.

In this district, practically all the inoculations have been given by the general practitioners.

During the year, 1779 vaccinations were carried out—of these 1665 were children and 114 over the age of fifteen years.

PERSONAL PRECAUTIONS AGAINST POLIOMYELITIS

The World Health Organisation has issued six points for the personal protection of the public against poliomyelitis.

The six rules for the individual to observe are as follows :—

- (1) Wash hands frequently, especially before eating
- (2) Protect food from flies ; thoroughly wash uncooked food, such as fruit and vegetables
- (3) Avoid intimate association, such as shaking hands with families in which poliomyelitis has occurred within three weeks
- (4) Treat feverish illnesses with caution ; bed rest, or at least avoiding over-exertion for a week is advisable
- (5) Avoid over-exertion
- (6) Avoid unnecessary travel to and from communities where the disease is prevalent

PREVALENCE OF, AND CONTROL OVER, INFECTIOUS AND OTHER DISEASES

NOTIFIABLE DISEASES

Particulars of the cases of Infectious Diseases, which were notified during the year and comparative notification rates for the whole of England and Wales, are shown in the following table :—

Diseases	Total Cases Notified	Rate per 1,000 of the Population	
		Droxford R.D.	England & Wales
Dysentery ...	102	4.78	0.84
Measles ...	134	6.29	5.72
Pneumonia ...	4	0.18	0.49
Scarlet Fever ...	3	0.14	0.85
Whooping Cough ...	11	0.51	0.73
Poliomyelitis ...	6	0.28	0.04
Food Poisoning ...	5	0.23	0.19

Only certain forms of pneumonia are notifiable.

An analysis of the total notified cases according to age groups is given below :—

Age Group	Dysentery	Measles	Pneumonia	Scarlet Fever	Whooping Cough	Poliomyelitis	Food Poisoning
Under 1 year ...	2	—	—	—	1	—	—
1 - 2 years ...	1	8	—	—	—	—	—
2 - 3 " ...	3	10	—	—	1	1	—
3 - 4 " ...	8	14	—	1	—	1	—
4 - 5 " ...	6	12	—	—	2	—	—
5 - 10 " ...	46	79	—	2	5	1	—
10 - 15 " ...	13	8	—	—	1	1	—
15 - 20 " ...	3	2	—	—	—	1	1
20 - 35 " ...	8	—	—	—	1	1	1
35 - 45 " ...	6	—	—	—	—	—	3
45 - 65 " ...	5	1	1	—	—	—	—
Over 65 " ...	1	—	3	—	—	—	—
TOTALS	102	134	4	3	11	6	5

The following table shows the number of infectious diseases notified during the year, and the parishes in which they occurred :—

Parish	Dysentery	Measles	Pneumonia	Scarlet Fever	Whooping Cough	Poliomyelitis	Food Poisoning
Bishop's Waltham ...	...	2	...	...	...	...	1
Boarhunt ...	...	2	...	...	...	...	1
Corhampton and Meonstoke	1	...	...	...	...	...	...
Curdrige ...	...	...	...	...	...	5	...
Denmead ...	73	26	...	...	1	...	1
Droxford ...	...	2	...	...	...	...	...
Durley ...	...	...	...	...	...	...	...
Exton ...	...	...	...	...	...	...	...
Hambledon ...	...	48	...	...	5	...	...
Shedfield ...	4	...	...	1	...	...	...
Soberton ...	...	...	...	...	2	...	2
Southwick and Widley	...	2	...	...	1	...	...
Swanmore ...	...	1	...	...	2	...	...
Upham ...	...	1	...	...	...	...	...
Warnford ...	...	11	...	1	...	...	...
West Meon ...	...	33	...	1	...	...	...
Wickham ...	24	6	4	...	...	1	...
TOTALS ...	102	134	4	3	11	6	5

POLIOMYELITIS IN CURDRIDGE

During the last week of September and the first week of October, five cases of poliomyelitis occurred in the Parish of Curdrige. These consisted of an adult, one child of school age and three of pre-school age.

All the cases were found to be due to Poliomyelitis Virus Type 1.

Routine investigation of the outbreak revealed that the sanitary conditions at the school are very satisfactory ; and there is little doubt that these and the hand-washing facilities, which the school children are encouraged to use regularly, played some part in preventing the spread of infection in the school.

SONNE DYSENTERY AT DENMEAD PRIMARY SCHOOL, 1958

During the month of June, an outbreak of Sonne Dysentery occurred at Denmead Primary School, which is a mixed Infants and Junior School with 234 pupils.

Following consultation with the local General Practitioners and the Director of the Public Health Laboratory, Winchester, it was decided that the best way of controlling this outbreak was to examine the stools of all children attending school; and it was considered that three consecutive specimens should be obtained for a satisfactory result.

The Head Teacher was very willing to assist in every way ; and, in order to enlist the help and co-operation that is so essential for success in an undertaking of this sort, a letter was sent out to all parents indicating what part they could play in attempting to check the spread of the outbreak.

In this letter, it was pointed out how very easily the disease was spread among children by personal contact and that the germs, which are passed in the stools of the patient, are generally carried by the hands—though they can be spread indirectly by recently contaminated toys or other articles ; so it was stressed how important it was for the patient always to wash his hands after using the toilet, especially as the germs can pass through toilet paper.

The danger of spread of infection is of course from bowel to hand to mouth, so the patient or "carrier" should preferably use *separate* crockery and feeding utensils and they should be disinfected after use. In fact, everyone should be extra particular about washing their hands, for anyone may pick up the germ from an unknown carrier and pass it on to children—as well as infect food and feeding utensils. It is also important to keep the lavatory seat clean with soap and water.

During an outbreak, the most responsible persons are the food handlers—not forgetting the family cook—and those in charge of young children.

Owing to the large number of pupils attending Denmead School, it was necessary to carry out the task of collecting the specimens in two operations, dealing at weekly intervals with three classes at a time.

Sterile bottles were handed to each child on three consecutive days at school, together with written instructions as to the method of obtaining the specimen ; and the child delivered the specimens to the teacher on the succeeding days for collection and transportation to the Laboratory.

If there was a positive result, the parent was advised to take her child to the doctor.

Thanks to the excellent co-operation of the parents and the school staff, operation " Collection " was successful.

The positive excretors were excluded from school. After treatment, further specimens were collected from their homes until the patients were considered free from infection.

On bacteriological investigation, the strains were found to be due to type 2.

The advantage of collective sampling of stools *from the school* would appear to have the following merits :—

- 1 The degree of infection in the school is quickly determined.
- 2 All positive excretors — including "symptomless excretors" — are detected.
- 3 The outbreak is shortened by early treatment of the "symptomless excretors."
- 4 The work of the Public Health Department is minimised by concentrating the collection of specimens to one place at the outset.

During the course of the outbreak, the Public Health Inspectors dealt with 1,103 specimens, of which over 400 had to be collected from the homes. I am grateful to the Director of the Winchester Public Health Laboratory who so willingly undertook the examinations.

I should also like to take this opportunity of thanking the General Practitioners who took such an active part in the outbreak. Their help was greatly appreciated ; and it is satisfactory to report that the existing pail closets have since been converted to water closets.

TUBERCULOSIS

At the end of the year, the total number of cases on the register was 241.

The following table gives the number of cases of Tuberculosis registered in the district at the beginning and end of 1958 :—

	<i>Respiratory</i>			<i>Non-Respiratory</i>		
	<i>M</i>	<i>F</i>	<i>Total</i>	<i>M</i>	<i>F</i>	<i>Total</i>
Number on Register at beginning of the year (1958)	108	60	168	31	32	63
New additions to the register during the year	4	13	17	—	1	1
Removals from the Register during the year	5	3	8	—	—	—
Number on Register at end of the year	107	70	177	31	33	64

Analysis of new cases and deaths according to age groups :—

Age Period			New Cases				Deaths			
			Respiratory		Non-Respiratory		Respiratory		Non-Respiratory	
			<i>M</i>	<i>F</i>	<i>M</i>	<i>F</i>	<i>M</i>	<i>F</i>	<i>M</i>	<i>F</i>
0 - 1	...	...	...	...	...	...	...	...	...	...
1 - 5	...	...	...	...	...	...	...	...	...	...
5 - 15	...	...	...	...	...	...	...	...	...	...
15 - 25	...	...	...	4	...	...	...	...	...	...
25 - 35	...	...	1	2	...	...	...	...	...	...
35 - 45	...	...	...	3	...	...	...	...	...	...
45 - 55	...	...	1	1	...	...	1	1	...	...
55 - 65	...	...	2	2	...	...	2	...	...	...
65 and over	...	...	...	1	...	1	...	...	...	...
Age unknown	...	...	...	...	...	...	...	...	...	...
Totals	...	...	4	13	—	1	3	1	—	—

Mass Radiography Survey

In June, 1958, the Southampton and Portsmouth Mobile X-ray Units visited seven villages in this district. 2,029 persons attended and the results were very satisfactory.

SCABIES

Facilities for the treatment of Scabies are available at Portsmouth Disinfestation Clinic.

Appointments for cases requiring treatment are made through this department.

Scabies should be regarded as a family infection ; and all members of the same family should present themselves for treatment simultaneously—whether or not they complain of “The Itch” and show evidence of scabies at the time. Otherwise an early case may escape detection and the parasite may thrive in one member and re-infect the others.

PEDICULOSIS

Where necessary, cases of Pediculosis (head lice) may be referred for treatment, by special appointment, at any of the following centres :—

Fareham
Eastleigh
Petersfield

whichever is the most convenient.

Pediculosis should also be regarded as a family infection ; and, when a child is found to be verminous, all the members of the family should offer themselves for examination. This wise practice would ensure that any undetected case in the family would receive immediate treatment and that there would be no further spread of infection to others.

NATIONAL ASSISTANCE ACT

No official action was taken under Section 47 of the National Assistance Act, 1948, during the year in connection with the removal to hospital of persons “who are suffering from grave chronic disease or, being aged, infirm or physically incapacitated, are living in insanitary conditions, and are unable to devote to themselves, and are not receiving from other persons, proper care and attention.”

One potential case was brought to the notice of this department and investigated ; but it was referred to the Area Welfare Officer and suitable arrangements were made—other than by using this drastic procedure.

The assistance given by the General Practitioners, the Welfare Officer, Public Health Inspectors and Health Visitors, is greatly appreciated in these difficult and distressing cases.

PROVISION OF SHORT STAY ACCOMMODATION IN OLD PEOPLE'S HOMES

I am indebted to Mr. F. J. Bryan Long, County Welfare Officer, for the following note upon the County Council's short stay scheme :—

The Welfare Committee of the County Council operate a scheme whereby any places temporarily vacant in the County Homes for old people are made available to elderly persons to enable the relatives or friends with whom they live to take a holiday.

Such temporary vacancies arise when residents are in hospital or away on holiday and when a new resident needs time to clear up his affairs. Some use is also made of sick bays during the summer months when there is less demand for nursing care.

This scheme has enabled families to take a rest from giving constant attention to elderly relatives and has been of help also in times of illness and other domestic crises, when a younger relative or friend has been temporarily unable to care for an elderly person.

During the year, a total of 78 old people in the County were given a holiday in this way, the length of stay varying between a week and a month.

Accommodation under this scheme cannot be offered to old people needing regular medical and nursing care ; generally they should be able to wash and dress themselves, get to the dining room for meals and attend to their own toilet.

Applications for short stay admission may be made either to the local Area Welfare Officer or direct to the County Welfare Officer at The Castle, Winchester.

HOME HELP SERVICE

Applications for Home Helps should be made to the District Organiser, Home Help Office, Town Hall, Petersfield. (Telephone, Petersfield 771, Extension 13).

THE REPORT OF THE SURVEYOR AND CHIEF PUBLIC HEALTH INSPECTOR

SANITARY CONDITIONS OF THE AREA

Water Supply

No extensions were made during the year and there are now piped supplies throughout the District provided by the Portsmouth and Gosport Water Company, the Southampton Corporation and two private estates.

Drainage and Sewerage

In April a public local inquiry was held into the Bishop's Waltham sewerage scheme and in December approval in principle was given by the Ministry of Housing and Local Government.

Public Cleansing

The cesspool emptying scheme, which allows for four free emptyings per year, continues in operation, as does the collection of night soil and household refuse.

The following summary gives particulars of work done during the year under review :—

<i>Dustbin Emptyings</i>	<i>Cesspool Emptyings</i>	<i>Cesspool Loads</i>	<i>E.C. Emptyings</i>
263,907	5,518	10,912	142,097

Household refuse is collected by direct labour fortnightly throughout the district with the exception of Bishop's Waltham, Shedfield and Wickham, where it is made weekly.

Salvage

I am pleased to be able to record for yet another year an increase in quantity of almost all items of salvage and in the total income received.

During the year there was a fall in waste paper prices. Mixed metals have this year been sorted and graded resulting in improved values being obtained.

The following amounts of salvageable materials were collected :—

	Tons	Cwts.	Qtrs.	Lbs.
Waste Paper	169	4	0	23
Steel and Iron	36	0	1	0
Mixed Metals	2	5	0	10
Rags and Woollens	7	14	2	19
Bottles -	461 gross			
Tyres -	92 (in number)			

Salvage is collected concurrently with refuse. The total receipts were £1,868 6s. 4d.

Comparative figures of waste paper collection are set out below :—

1956	1957	1958
Weight—134 tons, 15 cwts.	151 tons, - cwts. 2 qtrs., 12 lbs.	169 tons, 4 cwts. - qtrs., 23 lbs.
Receipts—£1,019 5s. 7d.	£1,161 0s. 7d.	£1,236 10s. 3d.

HOUSING STATISTICS (Public Health)

Inspection of Dwelling-houses during the year :—

(1)	(a)	Total number of dwelling-houses inspected for housing defects (under Public Health or Housing Acts) ...	38
	(b)	Number of inspections made for the purpose	141
(2)	(a)	Number of dwelling-houses (included under subhead (1) above) which were inspected and recorded under the Housing Consolidated Regulations, 1925 and 1932 ...	20
	(b)	Number of inspections made for the purpose	104
(3)		Number of dwelling-houses found to be in a state so dangerous or injurious to health as to be unfit for human habitation ...	20
(4)		Number of dwelling-houses (exclusive of those referred to under the preceding sub-head) found not to be, in all respects, reasonably fit for human habitation ...	Nil

Remedy of Defects during the year without service of Formal Notices :—

Number of defective dwelling-houses rendered fit in consequence of informal action by the Local Authority or their officers ...	2
---	---

Action under Statutory Powers during the year :—

(a) Proceedings under Sections 9, 10 and 16 of the Housing Act, 1936 :—			
(1)	Number of dwelling-houses in respect of which Notices were served requiring repairs	Nil	
(2)	Number of dwelling-houses which were rendered fit after service of formal notices :		
(a)	By Owners	Nil	
(b)	By Local Authority in default of owners	Nil	
(b) Proceedings under Public Health Acts :—			
(1)	Number of dwellings in respect of which Notices were served requiring default to be remedied	2	
(2)	Number of dwelling-houses in which defaults were remedied after service of formal notices :		
(a)	By Owners	1	
(b)	By Local Authority in default of owners	Nil	
(c) Proceedings under Section 11 and 13 of the Housing Act, 1936 :—			
(1)	Number of dwelling-houses in respect of which Demolition Orders were made ...	16	
(2)	Number of dwelling-houses demolished in pursuance of Demolition Orders ...	15	
(3)	Undertakings given	1	

Overcrowding

Statutory overcrowding does exist in a minor degree within the area, but, under existing circumstances, no direct action is taken ; cases are referred to the appropriate Committee for consideration when allocating new houses.

Housing Act, 1949

Housing Repairs and Rents Act, 1954

Rent Act, 1957

Number of inspections made	151
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New Houses and Buildings

Comparative figures are given for the last nine years:—

Number of Plans approved by the Council:—

PURPOSE OF PLAN	1950	1951	1952	1953	1954	1955	1956	1957	1958
Houses	30	32	51	58	146	112	148	119	137
Additions and Alterations	67	55	46	52	56	81	52	49	43
Conversions and Adaptations	7	14	10	9	6	11	6	5	5
Garages	36	32	41	44	44	101	60	81	87
Bathrooms and Drainage Installations	51	41	49	72	61	100	80	108	71
Farm Buildings	38	37	22	22	17	2	1	8	5
Sheds and Stores	9	17	12	15	6	13	9	3	5
Shops, Halls, Offices, etc.	—	—	—	—	—	3	11	4	15

The number of new units of housing erected by private enterprise or provided by the Local Authority over the same period was:—

BY WHOM ERECTED OR PROVIDED	1950	1951	1952	1953	1954	1955	1956	1957	1958
By Private Enterprise	18	14	37	37	47	90	108	115	87
By Local Authority—									
(a) Houses	79	40	46	56	72	61	31	35	27
(b) Hutments	6	—	—	10	—	—	—	—	—

On the 31st December, 1958, there were a further twenty-two Council Houses in course of erection.

Housing (Financial Provisions) Act, 1958

The reduction in number and amount of Improvement Grants was due in part to the change of policy by the Council at the end of 1957 when the percentage grant was reduced and a lower maximum fixed.

The following table gives the comparative figures for the number of applications and the amount of grants approved for each year :—

Year	No. of Applications approved	New Units of Housing provided	No. of houses improved	Owner Occupiers	Tenanted	Total amounts approved £
1952	4	—	7	2	5	508 (£36 recovered)
1953	2	—	3	—	3	317
1954	14	—	17	5	12	4225
1955	48	4	65	23	46	16210 (£185 unpaid due to withdrawal)
1956	55	1	60	27	34	16132
1957	60	2	72	32	42	18623
1958	33	2	34	18	18	6325
TOTALS	216	9	258	107	160	62340

INSPECTION AND SUPERVISION OF FOOD

Milk Supply

Under the Milk (Special Designations) (Specified Areas) (No. 2) Order, 1954, all milk sold by retail within the Droxford Rural District must be either Tuberculin Tested or Pasteurised.

The Licensing of Producers/Retailers remains the duty of the Ministry of Agriculture, Fisheries and Food, while the licensing of Dealers is the responsibility of the Local Authority.

Licences issued under the Milk (Special Designations) (Pasteurised and Sterilised Milk) Regulations, 1949 :—

Dealers' Licences to use the designation " Pasteurised "	...	6
Supplementary Licences to use the designation " Pasteurised "	..	10
Supplementary Licences to use the designation " Sterilised "	...	4

Licences issued under the Milk (Special Designation) (Raw Milk) Regulations, 1949 :—

Dealers' Licences to use the designation " Tuberculin Tested,, "	...	6
Supplementary Licences to use the designation " Tuberculin Tested "		10

Fifteen samples of milk were taken during the year and submitted to the Public Health Laboratory, Winchester, for examination. The results were very satisfactory.

Food Hygiene Regulations, 1955

Alterations have been made to several food premises and the opportunity has been taken to bring them up to the required standards.

Meat Inspection

Since the establishment of the Wessex Slaughterhouses Board, all meat inspection for this area is done at the Funtley Abattoir, Fareham, except the inspection of pigs slaughtered at Knowle Mental Hospital for consumption on Crown Property. This slaughterhouse is exempt from licensing.

There remains one knacker's yard in the district, which is licensed by the Wessex Slaughterhouses Board on receipt of recommendation from this Authority.

Food Adulteration

This section of the Food and Drugs Act, 1955, is operated by the County Council.

Details of the samples taken under the Food and Drugs Act, 1955, during the year ended 31st March, 1959 :—

ARTICLE	Number taken	
	Genuine	Unsatisfactory
Butter	3	—
Cream	2	—
Drugs	3	—
Ice Cream	1	—
Meat Products	4	—
Milk	35	6
Milk, Channel Island	18	—
Preserves	2	—
Spirits	7	—
Other Foods	2	—
TOTAL	77	6

Unsatisfactory Samples

The six unsatisfactory milk samples were all taken from one estate from milk intended for employees.

The employer was prosecuted and fined.

RODENT CONTROL

Work on this was maintained throughout the year and block control was carried out—no new major infestations were found. The following tables give an analysis of the prevalence and control of rats and mice within the district for the twelve months ending 31st March, 1959:—

1. PREVALENCE OF RATS AND MICE.

	(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)
		Number of properties in Local Authority's Area.			Analysis of Column iv.		
TYPE OF PROPERTY.	Total.	In which infestation was			Number infested by		
		Notified by Occupier.	Otherwise discovered.	Recorded total of (ii) and (iii)	Rats.		Mice only.
					Major.	Minor.	
Local Authority's Property (not including houses) ...	12	...	3	3	...	3	...
Dwelling Houses ...	5879	112	113	225	...	225	...
Business Premises ...	587	...	8	8	...	8	...
Agricultural Property ...	550	...	10	10	...	10	...
TOTAL ...	7028	112	134	246	...	246	...

2. MEASURES OF CONTROL BY LOCAL AUTHORITY.

TYPE OF PROPERTY.	No. of properties inspected.	No. of inspections made.	Number of notices served under Section 4.		Number of treatments carried out.				Block treatments of properties in different occupancies under Section 6 (1) or by informal arrangement.			
					By arrangement with occupier.		Under Section 5 (1).					
			Treatments.	Works.	Rats.	Mice only.	Rats.	Mice only.	Number of blocks.	Surface.	Associated sewers.	
Local Authority's Property	12	42	...	...	34	...	...	...	...	...	...
Dwelling Houses	2369	2369	...	...	250	...	...	...	51	225	...
Business Premises	107	169	...	...	32	...	...	...	...	...	...
Agricultural Property	154	154	...	...	...	...	...	...	...	...	...
TOTAL	2642	2734	...	...	316	...	...	...	51	225	...

SUMMARY OF INSPECTIONS MADE AND NOTICES SERVED

BUILDING INSPECTIONS

Foundations	150
Concrete over site	93
Damp Proof Courses	107
Intermediate	621
Drains Tested	296
Final Inspections	144
Buildings Inquiries Inspections	41
Short-lived Materials Section 53	20
Council House Inspections	1
Town Planning Inspections	52

PUBLIC HEALTH ACT, 1936

Drains and Sewer Ditches controlled by the Council ...	25
Blocked and Insanitary Drains and Cesspools ...	161
Defective and Insanitary Closet Accommodation ...	1
Refuse Tips	0
Filthy and Verminous Premises	8
Verminous Persons	0
Disinfestations	9
Nuisances (other than Houses) Section 92	15
Re-inspections for the purpose	13
Water Supply	16
Infectious Diseases (visits)	762
Disinfections	9
Moveable Dwellings, Section 269	88
Other Inspections	346

FOOD AND DRUGS ACT, 1955

Carcases Inspected	55
Inspections, other Foods	3
Food Premises, Section 13	15
Milk Distribution	19
Slaughter-houses and Knackers' Yards	0

FACTORIES ACT, 1937

Power Factories	1
Non-Power Factories	4
Out-Workers	0
Other Premises	0

PETROLEUM REGULATIONS

Inspections	13
-------------	-----	-----	----	-----	-----	----

MISCELLANEOUS

Rodent Control (by Public Health Inspector)	...	...	...	...	0
Housing Applications	...	...	...	...	38
Other Visits	...	...	...	...	223

SAMPLES TAKEN

Water	...	...	...	...	34
Milk	...	...	...	...	15
Ice Cream	...	...	...	...	0
Other Samples	...	...	...	...	9

FACTORIES ACT, 1937

Part 1 of the Act

1. **Inspections** for the purpose as to health

PREMISES	Number on Register	Inspections	Number of written Notices
Factories with mechanical power ...	55	1	—
Factories without mechanical power	6	4	—
Other premises under the Act (including works of building and engineering construction, but not including outworkers premises) ...	—	—	—
TOTALS	61	5	—

